

EXHIBIT E

United States Bankruptcy Court, District of New Jersey (Newark)

Fill in this information to identify the case (Select only one Debtor per claim form):			
<input checked="" type="checkbox"/> Bed Bath & Beyond Inc. (Case No. 23-13359)	<input type="checkbox"/> Alamo Bed Bath & Beyond Inc. (Case No. 23-13360)	<input type="checkbox"/> BBB Canada LP Inc. (Case No. 23-13361)	<input type="checkbox"/> BBB Value Services Inc. (Case No. 23-13362)
<input type="checkbox"/> BBBY Management Corporation (Case No. 23-13363)	<input type="checkbox"/> BBBYCF LLC (Case No. 23-13364)	<input type="checkbox"/> BBBYTF LLC (Case No. 23-13365)	<input type="checkbox"/> bed 'n bath Stores Inc. (Case No. 23-13396)
<input type="checkbox"/> Bed Bath & Beyond of Annapolis, Inc. (Case No. 23-13366)	<input type="checkbox"/> Bed Bath & Beyond of Arundel Inc. (Case No. 23-13367)	<input type="checkbox"/> Bed Bath & Beyond of Baton Rouge Inc. (Case No. 23-13368)	<input type="checkbox"/> Bed Bath & Beyond of Birmingham Inc. (Case No. 23-13369)
<input type="checkbox"/> Bed Bath & Beyond of Bridgewater Inc. (Case No. 23-13370)	<input type="checkbox"/> Bed Bath & Beyond of California Limited Liability Company (Case No. 23-13371)	<input type="checkbox"/> Bed Bath & Beyond of Davenport Inc. (Case No. 23-13372)	<input type="checkbox"/> Bed Bath & Beyond of East Hanover Inc. (Case No. 23-13373)
<input type="checkbox"/> Bed Bath & Beyond of Edgewater Inc. (Case No. 23-13374)	<input type="checkbox"/> Bed Bath & Beyond of Falls Church, Inc. (Case No. 23-13375)	<input type="checkbox"/> Bed Bath & Beyond of Fashion Center, Inc. (Case No. 23-13376)	<input type="checkbox"/> Bed Bath & Beyond of Frederick, Inc. (Case No. 23-13377)
<input type="checkbox"/> Bed Bath & Beyond of Gaithersburg Inc. (Case No. 23-13378)	<input type="checkbox"/> Bed Bath & Beyond of Gallery Place L.L.C. (Case No. 23-13379)	<input type="checkbox"/> Bed Bath & Beyond of Knoxville Inc. (Case No. 23-13380)	<input type="checkbox"/> Bed Bath & Beyond of Lexington Inc. (Case No. 23-13381)
<input type="checkbox"/> Bed Bath & Beyond of Lincoln Park Inc. (Case No. 23-13382)	<input type="checkbox"/> Bed Bath & Beyond of Louisville Inc. (Case No. 23-13383)	<input type="checkbox"/> Bed Bath & Beyond of Mandeville Inc. (Case No. 23-13384)	<input type="checkbox"/> Bed, Bath & Beyond of Manhattan, Inc. (Case No. 23-13397)
<input type="checkbox"/> Bed Bath & Beyond of Opry Inc. (Case No. 23-13385)	<input type="checkbox"/> Bed Bath & Beyond of Overland Park Inc. (Case No. 23-13386)	<input type="checkbox"/> Bed Bath & Beyond of Palm Desert Inc. (Case No. 23-13387)	<input type="checkbox"/> Bed Bath & Beyond of Paradise Valley Inc. (Case No. 23-13388)
<input type="checkbox"/> Bed Bath & Beyond of Pittsford Inc. (Case No. 23-13389)	<input type="checkbox"/> Bed Bath & Beyond of Portland Inc. (Case No. 23-13390)	<input type="checkbox"/> Bed Bath & Beyond of Rockford Inc. (Case No. 23-13391)	<input type="checkbox"/> Bed Bath & Beyond of Towson Inc. (Case No. 23-13392)
<input type="checkbox"/> Bed Bath & Beyond of Virginia Beach Inc. (Case No. 23-13393)	<input type="checkbox"/> Bed Bath & Beyond of Waldorf Inc. (Case No. 23-13394)	<input type="checkbox"/> Bed Bath & Beyond of Woodbridge Inc. (Case No. 23-13395)	<input type="checkbox"/> Buy Buy Baby of Rockville, Inc. (Case No. 23-13398)
<input type="checkbox"/> Buy Buy Baby of Totowa, Inc. (Case No. 23-13399)	<input type="checkbox"/> Buy Buy Baby, Inc. (Case No. 23-13400)	<input type="checkbox"/> BWA0 LLC (Case No. 23-13401)	<input type="checkbox"/> Chef C Holdings LLC (Case No. 23-13402)
<input type="checkbox"/> Decorist, LLC (Case No. 23-13403)	<input type="checkbox"/> Deerbrook Bed Bath & Beyond Inc. (Case No. 23-13404)	<input type="checkbox"/> Harmon of Brentwood, Inc. (Case No. 23-13405)	<input type="checkbox"/> Harmon of Caldwell, Inc. (Case No. 23-13406)
<input type="checkbox"/> Harmon of Carlstadt, Inc. (Case No. 23-13407)	<input type="checkbox"/> Harmon of Franklin, Inc. (Case No. 23-13408)	<input type="checkbox"/> Harmon of Greenbrook II, Inc. (Case No. 23-13409)	<input type="checkbox"/> Harmon of Hackensack, Inc. (Case No. 23-13410)
<input type="checkbox"/> Harmon of Hanover, Inc. (Case No. 23-13411)	<input type="checkbox"/> Harmon of Hartsdale, Inc. (Case No. 23-13412)	<input type="checkbox"/> Harmon of Manalapan, Inc. (Case No. 23-13413)	<input type="checkbox"/> Harmon of Massapequa, Inc. (Case No. 23-13414)
<input type="checkbox"/> Harmon of Melville, Inc. (Case No. 23-13415)	<input type="checkbox"/> Harmon of New Rochelle, Inc. (Case No. 23-13416)	<input type="checkbox"/> Harmon of Newton, Inc. (Case No. 23-13417)	<input type="checkbox"/> Harmon of Old Bridge, Inc. (Case No. 23-13418)
<input type="checkbox"/> Harmon of Plainview, Inc. (Case No. 23-13419)	<input type="checkbox"/> Harmon of Raritan, Inc. (Case No. 23-13420)	<input type="checkbox"/> Harmon of Rockaway, Inc. (Case No. 23-13421)	<input type="checkbox"/> Harmon of Shrewsbury, Inc. (Case No. 23-13422)
<input type="checkbox"/> Harmon of Totowa, Inc. (Case No. 23-13423)	<input type="checkbox"/> Harmon of Wayne, Inc. (Case No. 23-13424)	<input type="checkbox"/> Harmon of Westfield, Inc. (Case No. 23-13425)	<input type="checkbox"/> Harmon of Yonkers, Inc. (Case No. 23-13426)
<input type="checkbox"/> Harmon Stores, Inc. (Case No. 23-13427)	<input type="checkbox"/> Liberty Procurement Co. Inc. (Case No. 23-13428)	<input type="checkbox"/> Of a Kind, Inc. (Case No. 23-13429)	<input type="checkbox"/> One Kings Lane LLC (Case No. 23-13430)
<input type="checkbox"/> San Antonio Bed Bath & Beyond Inc. (Case No. 23-13431)	<input type="checkbox"/> Springfield Buy Buy Baby, Inc. (Case No. 23-13432)		

Modified Official Form 410

Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

Part 1: Identify the Claim

1. Who is the current creditor?	Carla Cox Smith Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor _____	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent? Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Where should notices to the creditor be sent? 7777 Bonhomme Ave #2100 St. Louis, MO 63105	Where should payments to the creditor be sent? (if different) Contact phone 314-863-0500 Contact email ben@missourilawyers.com
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No Yes. Claim number on court claims registry (if known) _____ Filed on ____ / ____ / ____ MM / DD / YYYY	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No Yes. Who made the earlier filing? _____	

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor?	<input checked="" type="checkbox"/> No Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ____	
7. How much is the claim?	\$ no less than 1,000,000.00 Does this amount include interest or other charges? <input checked="" type="checkbox"/> No Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).	
8. What is the basis of the claim?	Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information. Personal injury (unliquidated)	

9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No	Yes. The claim is secured by a lien on property. Nature of property: Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i> . Motor vehicle Other. Describe: _____
Basis for perfection: _____ Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)		
Value of property: \$ _____		
Amount of the claim that is secured: \$ _____		
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)		
Amount necessary to cure any default as of the date of the petition: \$ _____		
Annual Interest Rate (when case was filed) _____ % Fixed Variable		

10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No	Yes. Amount necessary to cure any default as of the date of the petition. \$ _____
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11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No	Yes. Identify the property: _____
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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)? A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	<input checked="" type="checkbox"/> No	Yes. Check one: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 20%; text-align: right;">Amount entitled to priority</th> </tr> </thead> <tbody> <tr> <td>Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Up to \$3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Wages, salaries, or commissions (up to \$15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.</td> <td style="text-align: right;">\$ _____</td> </tr> </tbody> </table>		Amount entitled to priority	Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____	Up to \$3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____	Wages, salaries, or commissions (up to \$15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	\$ _____	Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____	Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____	Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____
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Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____															
Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____															

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. Is all or part of the claim entitled to administrative priority pursuant to 11 U.S.C. § 503(b)(9)?

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the Debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

\$ _____

14. Is all or part of the claim being asserted as an administrative expense claim?

☒ No

☐ Yes. Indicate the amount of your claim for costs and expenses of administration of the estates pursuant to 503(b), other than section 503(b)(9), or 507(a)(2). Attach documentation supporting such claim. If yes, please indicate when this claim was incurred:

☐ On or prior to June 27, 2023:

\$ _____

☐ After June 27, 2023:

\$ _____

Total Administrative Expense Claim Amount:

\$ _____

THIS SECTION SHOULD ONLY BE USED BY CLAIMANTS ASSERTING AN ADMINISTRATIVE EXPENSE CLAIM ARISING AGAINST ONE OF THE ABOVE DEBTORS FOR POSTPETITION ADMINISTRATIVE CLAIMS. THIS SECTION SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(B) AND 507(A)(2); PROVIDED, HOWEVER; THIS SECTION SHOULD NOT BE USED FOR CLAIMS PURSUANT TO SECTION 503(B)(9) OF THE BANKRUPTCY CODE.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

- ☐ I am the creditor.
☒ I am the creditor's attorney or authorized agent.
☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 12/29/2023

MM / DD / YYYY

/s/ Ben Sansone

Signature

Name of the person who is completing and signing this claim:

Name Ben Sansone
First name Middle name Last name

Title Attorney

Company Sansone and Lauber
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 7777 Bonhomme Ave #2100
Number Street

St. Louis MO
City State ZIP Code

Contact phone 314-863-0500 Email ben@missourilawyers.com

Modified Official Form 410

Instructions for Proof of Claim

United States Bankruptcy Court

12/15

These instructions and definitions generally explain the law. In certain circumstances, such as bankruptcy cases that debtors do not file voluntarily, exceptions to these general rules may apply. You should consider obtaining the advice of an attorney, especially if you are unfamiliar with the bankruptcy process and privacy regulations.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both.
18 U.S.C. §§ 152, 157 and 3571.

How to fill out this form

- Fill in all of the information about the claim as of the date the case was filed.
- Fill in the caption at the top of the form.
- If the claim has been acquired from someone else, then state the identity of the last party who owned the claim or was the holder of the claim and who transferred it to you before the initial claim was filed.
- Attach any supporting documents to this form.
Attach redacted copies of any documents that show that the debt exists, a lien secures the debt, or both. (See the definition of *redaction* on the next page.)

Also attach redacted copies of any documents that show perfection of any security interest or any assignments or transfers of the debt. In addition to the documents, a summary may be added. Federal Rule of Bankruptcy Procedure (called “Bankruptcy Rule”) 3001(c) and (d).
- Do not attach original documents because attachments may be destroyed after scanning.
- If the claim is based on delivering health care goods or services, do not disclose confidential health care information. Leave out or redact confidential information both in the claim and in the attached documents.

- A **Proof of Claim** form and any attached documents must show only the last 4 digits of any social security number, individual’s tax identification number, or financial account number, and only the year of any person’s date of birth. See Bankruptcy Rule 9037.
- For a minor child, fill in only the child’s initials and the full name and address of the child’s parent or guardian. For example, write *A.B., a minor child (John Doe, parent, 123 Main St., City, State)*. See Bankruptcy Rule 9037.

Confirmation that the claim has been filed

To receive confirmation that the claim has been filed, enclose a stamped self-addressed envelope and a copy of this form. You may view a list of filed claims in this case by visiting the Claims and Noticing Agent’s website at <https://restructuring.ra.kroll.com/BBBY>.

Understand the terms used in this form

Administrative expense: Generally, an expense that arises after a bankruptcy case is filed in connection with operating, liquidating, or distributing the bankruptcy estate.
11 U.S.C. § 503.

Claim: A creditor’s right to receive payment for a debt that the debtor owed on the date the debtor filed for bankruptcy.
11 U.S.C. §101 (5). A claim may be secured or unsecured.

Claim Pursuant to 11 U.S.C. §503(b)(9): A claim arising from the value of any goods received by the Debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of the Debtor's business. Attach documentation supporting such claim.

Creditor: A person, corporation, or other entity to whom a debtor owes a debt that was incurred on or before the date the debtor filed for bankruptcy. 11 U.S.C. §101 (10).

Debtor: A person, corporation, or other entity who is in bankruptcy. Use the debtor's name and case number as shown in the bankruptcy notice you received. 11 U.S.C. § 101 (13).

Evidence of perfection: Evidence of perfection of a security interest may include documents showing that a security interest has been filed or recorded, such as a mortgage, lien, certificate of title, or financing statement.

Information that is entitled to privacy: A *Proof of Claim* form and any attached documents must show only the last 4 digits of any social security number, an individual's tax identification number, or a financial account number, only the initials of a minor's name, and only the year of any person's date of birth. If a claim is based on delivering health care goods or services, limit the disclosure of the goods or services to avoid embarrassment or disclosure of confidential health care information. You may later be required to give more information if the trustee or someone else in interest objects to the claim.

Priority claim: A claim within a category of unsecured claims that is entitled to priority under 11 U.S.C. §507(a). These claims are paid from the available money or property in a bankruptcy case before other unsecured claims are paid. Common priority unsecured claims include alimony, child support, taxes, and certain unpaid wages.

Proof of claim: A form that shows the amount of debt the debtor owed to a creditor on the date of the bankruptcy filing. The form must be filed in the district where the case is pending.

Redaction of information: Masking, editing out, or deleting certain information to protect privacy. Filers must redact or leave out information entitled to **privacy** on the *Proof of Claim* form and any attached documents.

Secured claim under 11 U.S.C. §506(a): A claim backed by a lien on particular property of the debtor. A claim is secured to the extent that a creditor has the right to be paid from the property before other creditors are paid. The amount of a secured claim usually cannot be more than the value of the particular property on which the creditor has a lien. Any amount owed to a creditor that is more than the value of the property normally may be an unsecured claim. But exceptions exist; for example, see 11 U.S.C. § 1322(b) and the final sentence of 1325(a).

Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment may be a lien.

Setoff: Occurs when a creditor pays itself with money belonging to the debtor that it is holding, or by canceling a debt it owes to the debtor.

Unsecured claim: A claim that does not meet the requirements of a secured claim. A claim may be unsecured in part to the extent that the amount of the claim is more than the value of the property on which a creditor has a lien.

Offers to purchase a claim

Certain entities purchase claims for an amount that is less than the face value of the claims. These entities may contact creditors offering to purchase their claims. Some written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court, the bankruptcy trustee, or the debtor. A creditor has no obligation to sell its claim. However, if a creditor decides to sell its claim, any transfer of that claim is subject to Bankruptcy Rule 3001(e), any provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.) that apply, and any orders of the bankruptcy court that apply.

Please send completed Proof(s) of Claim to:

If by first class mail:

Bed Bath & Beyond Inc. Claims Processing Center
c/o Kroll Restructuring Administration LLC
Grand Central Station, PO Box 4850
New York, NY 10163

If by overnight courier or hand delivery:

Bed Bath & Beyond Inc. Claims Processing Center
c/o Kroll Restructuring Administration LLC
850 3rd Avenue, Suite 412
Brooklyn, NY 11232

You may also file your claim electronically at
<https://restructuring.ra.kroll.com/BBBY/EPOC-Index>.

Do not file these instructions with your form

ADVANCED INJURY CARE

Post Op Follow Up Note

8225 Clayton Road, Saint Louis, MO 631171107

CARLA COX SMITH

MRN :

Birthday :

Phone :

Visited on: 2023 Aug 03 15:00 (Age at visit: 63 years)

Electronically signed by: GEORGE PALETTA, M.D. on 2023-08-17 09:02 AM

HPI

HPI

Carla returns today for an initial postop visit status post revision rotator cuff repair. At the time of surgery, the bulk of her previous repair had healed. She had a re-tear at the edge of the repair at one of the anchor sites that extended for about a centimeter or so. She returns today for follow up stating she is doing well. She denies any wound drainage or fevers. She's been compliant with the sling and abduction pillow. She states overall her pain control has been good.

EXAM

Examination of the left shoulder reveals surgical incisions to be well healed. No sign of infection. Forward elevation is to 90. External rotation is to neutral. Internal and external rotation activation is good. Deltoid fires nicely. Neurovascular status is intact.

RESULTS

No radiographs obtained today.

IMPRESSION

Doing well.

PLAN

I reviewed with her the findings at the time of surgery. Given the fact this is a revision, we will hold off on starting physical therapy until after the fourth week. As such, she will not start therapy until the week of 8-14-23. She will remain in the sling for a total of six weeks but she does not require the abduction pillow. She can come out of the sling for light activities such as self-care, keyboarding and utensils to eat. We will see her back for follow up in four weeks. X-rays at that time include a left shoulder series. Expectation is she should be ready to discontinue the sling.

George A. Paletta, Jr., M.D.

GAP:kh

This report was dictated by George A. Paletta, Jr. and approved without proofreading/editing to expedite distribution.

ADVANCED INJURY CARE

Post Op Follow Up Note

8225 Clayton Road, Saint Louis, MO 631171107

CARLA COX SMITH

MRN :

Birthday :

Visited on: 2023 Sep 14 13:30 (Age at visit: 63 years)

Phone :

Electronically signed by: GEORGE PALETTA, M.D. on 2023-09-18 08:58 AM

HPI

Carla returns today for continued follow up of her left shoulder. She is status post an initial rotator cuff repair that was performed in February 2023. She was progressing nicely from that but unfortunately was involved in a second motor vehicle accident that resulted in recurrent left shoulder pain and evidence of a recurrent rotator cuff tear. This precipitated a second surgery including arthroscopy of the left shoulder with revision rotator cuff repair. That surgery was performed on July 17, 2023. She returns for follow up today.

Overall, she is doing well. She is very pleased with her progression of range of motion. She is really having minimal pain at this point. She has been doing her physical therapy at Athletico. An update from the therapist documents excellent compliance and good range of motion. The patient is pleased with her progress.

With respect to her neck, she has continued with chiropractic treatment at this point. There were some discussions with regard to interventions at the cervical spine, but she has preferred to continue to go the chiropractic route and reports overall things are doing okay with regard to the neck.

EXAM

Examination of the left shoulder reveals surgical incisions to be well healed. Range of motion is outstanding. She has full forward elevation to 170. Abduction is to 160. She has no residual shoulder shrug. 30 degrees of rotation with the arm at the side. Her cuff is firing nicely. Internal and external rotation strength are 5-/5. Supraspinatus strength was not assessed but she sets her shoulder nicely with no shoulder shrug and no pain.

RESULTS

No radiographs taken today.

IMPRESSION

1. Doing well.

PLAN

She has met and exceeded all the goals and milestones of the first phase of therapy. She will now progress to Phase 2 working on progressive rotator cuff strengthening. The plan is to see her back for follow up in about six to eight weeks, whatever works for her schedule and mine. At that point, I would anticipate she will likely be done with physical therapy and ready to go to a home exercise program. Obviously, she should continue treatment for her cervical spine based on the recommendations of those providers. I addressed her questions.

George A. Paletta, Jr., M.D.

GAP: sdm

This report was dictated by#George A. Paletta, Jr.#and approved without proofreading/editing to expedite distribution.

ADVANCED INJURY CARE

Post Op Follow Up Note

8225 Clayton Road, Saint Louis, MO 631171107

CARLA COX SMITH

MRN :

Birthday :

Phone :

Visited on: 2023 Nov 09 13:30 (Age at visit: 64 years)

Electronically signed by: GEORGE PALETTA, M.D. on 2023-11-13 02:34 PM

HPI

Carla returns today for continued follow up of her left shoulder. She is status post initial rotator cuff repair performed on 2-13-23. She was doing well in her course of recovery but then unfortunately was involved in a second motor vehicle accident that resulted in recurrent and increasing left shoulder pain. She underwent an evaluation at that time which showed evidence of a recurrent rotator cuff tear requiring revision surgery.

The revision surgery was performed on 7-18-23. She returns today for follow up stating overall she is doing well. She still notes some occasional discomfort at night. She has been progressing with physical therapy. She feels like she's done so much therapy at this point that she can do most of it on her own. Overall, she feels like it continues to improve steadily.

EXAM

Examination of the left shoulder reveals outstanding motion. She has full forward elevation and abduction to 170 with normal kinematics. She has restored full rotational range of motion including external rotation at the side as well as in the 90/90 position. She has good cuff function. Internal and external rotation strength are 5/5. Supraspinatus strength is 5-/5 with no residual shoulder shrug and minimal discomfort on resisted manual testing. Impingement signs are negative.

RESULTS

No radiographs obtained today.

IMPRESSION

Mild residual supraspinatus weakness status post revision rotator cuff repair.

PLAN

In my opinion, Carla can back off to once a week for physical therapy for the next three or four weeks and transition to a home exercise program thereafter. In my opinion, she requires no specific restrictions or limitations at this point. Obviously, anything that causes discomfort in the shoulder she should avoid or back off on. I would like to see her back for follow up in eight weeks. At that point she'll be about a month into a home exercise program. If she's doing well, she'll be released from care at that point. I addressed her questions.

George A. Paletta, Jr., M.D.

GAP:kh

This report was dictated by#George A. Paletta, Jr.#and approved without proofreading/editing to expedite distribution.



Patient: Cox Smith, Carla

DOB: [REDACTED]

DOS: 03/29/2023 10:30 AM

Person #: 1283611

Attended Appointments: 7

Cancelled Appointments: 1

Payer: Lien

Ref Phys Fax: (314) 336-2639

Ref Phys: George Paletta Jr MD

CC:

Case Contacts:

Name	Phone	Fax	Email
Paletta Jr MD, George	(314) 336-2555	(314) 658-9684	
Ben Sansone	(314) 863-0503		heather@missourilawyers.com

Diagnosis:

Strain of musc/tend the rotator cuff of left shoulder, subs S46.012D

Encounter for other orthopedic aftercare Z47.89

Dear George Paletta Jr MD,

Thank you for your referral of Carla Cox Smith to Athletico's center in Florissant.

Assessment:

Patient was re-educated on not using UE per MD protocol and the risks of not following MD orders. Patient has been told on multiple occasions to not use her UE to lift, throw, push or pull. Patient states, "wow, I didn't realize how serious it is. But I can tell by your tone of voice that it is... thank you for re-iterating it to me." Patient is just over 6 weeks, plan to progress into early strengthening phase (6-14 weeks post-op).

Subjective:

Patient reports she is feeling fine. She states she missed therapy yesterday due to dealing with family issues.

Objective:

Patient is observed to hold her arm up in the air in a supine position.

Patient is observed to toss swiss ball with B UE after doing wall slides.

Full PROM.

Goals:

Short Term Goals	Status	Type	Achieved
Patient will be able to reach to shoulder height shelf by 5/1/2023.	In Progress	STG	
Long Term Goals	Status	Type	Achieved
Patient will be able to reach OH shelf by 6/1/2023.	In Progress	LTG	
Patient will be able to reach behind her back to tuck in her shirt by 6/1/2023.	In Progress	LTG	
Patient will be able to carry 5 lbs unilaterally to improve her ability to carry groceries by 6/1/2023.	In Progress	LTG	

Plan:

Plan to progress with gentle shoulder AROM and rotator cuff strength at modified neutral.

Thank you, again, for the referral of Carla Cox Smith to Athletico's center in Florissant. Please feel free to contact me with any questions at (314)972-1442.

Rendering: Gillette PT, DPT, Sara Location: Florissant Location Phone: (314)972-1442 Location Fax: (314)972-1533

Sincerely,

Electronically signed by Sara Gillette PT, DPT on 03/30/2023 02:58 PM

STATE OF MISSOURI

COUNTY OF ST. LOUIS

**AFFIDAVIT AS TO BILLING RECORDS, REASONABLENESS OF MEDICAL
CHARGES AND NECESSITY OF TREATMENT**

Before me, the undersigned authority, personally appeared GUENN TAYLOR
who, being duly sworn, states as follows:

My name is GUENN TAYLOR, I am of sound mind, capable of making this
affidavit, and personally acquainted with the facts herein stated:

I am the custodian of records and designee of the entity who provided services to
the patient named below.

Attached to this Affidavit is 19 page(s) of billing records reflecting services
and charges by ADVANCED INJURY CARE to Carla Cox Smith, date
of birth [REDACTED]. These records were kept in the regular course of business
and the records were made at or near the time the services and charges were rendered.
The amounts charged for the itemized services were reasonable at the time and place the
services were provided.

ADVANCED INJURY CARE deemed the services necessary to treat Carla Cox Smith

[Signature]
AFFIANT

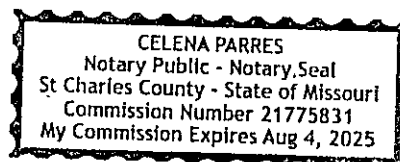
In witness whereof, I have hereunto subscribed my name and affixed my official
seal, this 31 day of MARCH, 2023

(SEAL)

[Signature]
Notary Public

My Term Expires:

8/4/2025



ADVANCED INJURY CARE

Itemization of Charges

For Posting Date March 31, 2023

Clinic: ADVANCED INJURY CARE

Address: 8225 Clayton Road
Saint Louis, MO 631171107

Phone: (314) 330-4776

Tax ID: 822699429

WCAB:

Insurance #1: Sansone & Lauber
7777 BONHOMME AVE
#2100
SAINT LOUIS, MO 63105

Adjuster:

Group Number

Policy Number: 0

Employer:

Insurance #2:

Patient #: 7569

Adjuster:

Patient: Carla Cox SMITH

Group Number:

Date of Injury:

Policy Number:

Visit #	Service Date	Provider Name	Procedure Description	Code	Charges	Adjust	Payments	Balance
16621	06/13/2022	LINDSEY PATERSON, PA-C	New patient office or othe...	99204	1,100.00	-	-	1,100.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Injection of substance int...	62321	2,815.24	-	-	2,815.24
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Injection, dexamethasone s...	J1100	350.00	-	-	350.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Low osmolar contrast mater...	Q9966	500.00	-	-	500.00
17523	07/06/2022	STEVEN STAHL, M.D.	Established patient office...	99213	550.00	-	-	550.00
18058	07/20/2022	KORRIN TILLEY, PA	Established patient office...	99213	550.00	-	-	550.00
19022	08/09/2022	LINDSEY PATERSON, PA-C	Established patient office...	99213	550.00	-	-	550.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Injection of anesthetic an...	64483	2,658.37	-	-	2,658.37
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Injection, dexamethasone s...	J1100	350.00	-	-	350.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Low osmolar contrast mater...	Q9966	500.00	-	-	500.00
19919	08/24/2022	NICOLE HELLWEG, PA-CMPAS	Established patient office...	99213	550.00	-	-	550.00
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd...	64490	3,274.98	-	-	3,274.98
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd...	64491	1,554.00	-	-	1,554.00
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd...	64490	3,274.98	-	-	3,274.98
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd...	64491	1,554.00	-	-	1,554.00
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Established patient office...	99213	550.00	-	-	550.00

ADVANCED INJURY CARE

Itemization of Charges

For Posting Date March 31, 2023

20140	08/30/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Destruction of upper or mi...	64633	17,000.00	-	-	17,000.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Destruction of upper or mi...	64634	8,000.00	-	-	8,000.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Established patient office...	99213	550.00	-	-	550.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
21457	09/22/2022	LINDSEY PATERSON, PA-C	Established patient office...	99213	550.00	-	-	550.00
24170	11/01/2022	LINDSEY PATERSON, PA-C	Established patient office...	99213	550.00	-	-	550.00
24060	11/07/2022	KALEN VESPOLI, M.D., AP	Established patient office...	99213	550.00	-	-	550.00
26476	12/15/2022	GEORGE PALETTA, M.D.	X-ray of shoulder, minimum...	73030	250.00	-	-	250.00
26476	12/15/2022	GEORGE PALETTA, M.D.	New patient office or othe...	99204	1,250.00	-	-	1,250.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Incision of shoulder tendo...	23405	12,951.85	-	-	12,951.85
31972	02/13/2023	GEORGE PALETTA, M.D.	Manipulation of shoulder j...	23700	2,554.86	-	-	2,554.86
31972	02/13/2023	GEORGE PALETTA, M.D.	Limited removal of abnorma...	29822	15,425.00	-	-	15,425.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Shaving of part of shoulde...	29826	15,702.80	-	-	15,702.80
31972	02/13/2023	GEORGE PALETTA, M.D.	Repair of shoulder rotator...	29827	21,138.00	-	-	21,138.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Cold or hot fluid bottle, ...	A9273	75.00	-	-	75.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Fluid circulating cold pad...	E0218	675.00	-	-	675.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Shoulder orthosis, acromio...	L3670	250.00	-	-	250.00
30597	02/23/2023	GEORGE PALETTA, M.D.	Follow-up visit after surg...	99024	-	-	-	-

TOTALS**121,154.08****BALANCE DUE****121,154.08**



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. W230XXA B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 06 13 22 06 13 22 11 99204 A 1100 00 1 NPI 1912584509																			
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 16621Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1100 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File LINDSEY S PATERSON, PA- SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
13. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0									
22. RESUBMISSION CODE										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 07 06 22 07 06 22 11 99213 A 550 00 1 NPI 1578672341																			
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 17523Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 550 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File STEVEN STAHL, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
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4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. W230XXD B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 07 06 22 07 06 22 11 62321 A 2815 24 1 NPI 1376981571																			
2 07 06 22 07 06 22 11 A4550 A 500 00 1 NPI 1376981571																			
3 07 06 22 07 06 22 11 Q9966 A 500 00 1 NPI 1376981571																			
4 07 06 22 07 06 22 11 J1100 A 350 00 1 NPI 1376981571																			
5 07 06 22 07 06 22 11 80176 A 100 00 1 NPI 1376981571																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 17442Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 4265 24 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SAMUEL N BARTMESS, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. W230XXD B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 07 20 22 07 20 22 11 99213 A 550 00 1 NPI 1710553540																			
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 18058Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 550 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File KORRIN N TILLEY, PA SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107 a. NPI b.									
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
13. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0									
22. RESUBMISSION CODE										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 08 09 22 08 09 22 11 99213 A 550 00 1 NPI 1912584509																			
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 19022Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 550 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File LINDSEY S PATERSON, PA- SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. W230XXD B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1 08 09 22 08 09 22 11 A4550 A 500 00 1 NPI 1376981571																			
2 08 09 22 08 09 22 11 Q9966 A 500 00 1 NPI 1376981571																			
3 08 09 22 08 09 22 11 J1100 A 350 00 1 NPI 1376981571																			
4 08 09 22 08 09 22 11 80176 A 100 00 1 NPI 1376981571																			
5 08 09 22 08 09 22 11 64483 A 2658 37 1 NPI 1376981571																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 19294Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 4108 37 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SAMUEL N BARTMESS, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
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ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
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d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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1 08 24 22 08 24 22 11 99213 A 550 00 1 NPI 1306401559																			
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
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27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 550 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
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PATIENT AND INSURED INFORMATION

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PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
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ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
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c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. W230XXD B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1 08 24 22 08 24 22 11 A4550 A 500 00 1 NPI 1376981571																			
2 08 24 22 08 24 22 11 80176 A 100 00 1 NPI 1376981571																			
3 08 24 22 08 24 22 11 64490 50 A 3274 98 2 NPI 1376981571																			
4 08 24 22 08 24 22 11 64491 50 A 1554 00 2 NPI 1376981571																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 20028Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 5428 98 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SAMUEL N BARTMESS, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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1 08 30 22 08 30 22 11 A4550 A 500 00 1 NPI 1376981571																			
2 08 30 22 08 30 22 11 80176 A 100 00 1 NPI 1376981571																			
3 08 30 22 08 30 22 11 64490 50 A 3274 98 2 NPI 1376981571																			
4 08 30 22 08 30 22 11 64491 50 A 1554 00 2 NPI 1376981571																			
5 08 30 22 08 30 22 11 99213 A 550 00 1 NPI 1376981571																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 20140Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 5978 98 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SAMUEL N BARTMESS, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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1 09 08 22 09 08 22 11 A4550 A 500 00 1 NPI 1376981571																			
2 09 08 22 09 08 22 11 80176 A 100 00 1 NPI 1376981571																			
3 09 08 22 09 08 22 11 99213 A 550 00 1 NPI 1376981571																			
4 09 08 22 09 08 22 11 64633 50 A 17000 00 2 NPI 1376981571																			
5 09 08 22 09 08 22 11 64634 50 A 8000 00 2 NPI 1376981571																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 20418Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 26150 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SAMUEL N BARTMESS, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			



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SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
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5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR										8. RESERVED FOR NUCC USE									
CITY FLORISSANT										CITY FLORISSANT									
STATE MO										STATE MO									
ZIP CODE 63034										ZIP CODE 63034									
TELEPHONE (Include Area Code) () -										TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File									
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. W230XXA B. M542 C. M545 D. 										23. PRIOR AUTHORIZATION NUMBER									
E. F. G. H. 										F. \$ CHARGES									
I. J. K. L. 										G. DAYS OR UNITS									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 09 22 22 09 22 22 11 99213 ABC 550 00 1 NPI 1912584509																			
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 21457Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 550 00									
29. AMOUNT PAID \$ 0 00										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File LINDSEY S PATERSON, PA- SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> </div> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> </div> </div>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA						3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F			
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA						5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR			
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR			
8. RESERVED FOR NUCC USE						CITY FLORISSANT			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						STATE MO			
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F b. OTHER CLAIM ID (Designated by NUCC) _____ c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER			
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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M542 B. M545 C. W230XXD D. M25512 E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____						23. PRIOR AUTHORIZATION NUMBER _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER 11 01 22 11 01 22 11 99213 ABCD						F. \$ CHARGES 550 00 1 G. DAYS OR UNITS 1 H. EPST Family Plan 1 I. ID. QUAL. NPI J. RENDERING PROVIDER ID. # 1912584509			
25. FEDERAL TAX I.D. NUMBER 822699429 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. 24170Z92068			
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 550 00			
29. AMOUNT PAID \$ 0 00						30. Rsvd for NUCC Use			
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33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107 a. NPI b. _____									

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PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
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4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
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ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0									
22. RESUBMISSION CODE										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 11 07 22 11 07 22 11 99213 ABCD 550 00 1 NPI 1942824636																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 24060Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 550 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File KALEN J VESPOLI, M.D., SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107																			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM/DD/YY MM/DD/YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM/DD/YY MM/DD/YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM/DD/YY QUAL.										15. OTHER DATE MM/DD/YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. M25512 B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 12 15 22 12 15 22 11 99204 A 1250 00 1 NPI 1497720825																			
2 12 15 22 12 15 22 11 73030 LT A 250 00 1 NPI 1497720825																			
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/> 822699429										26. PATIENT'S ACCOUNT NO. 26476Z92068 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File GEORGE PALETTA, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107 a. NPI b.									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107 a. NPI b.																			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. M25512 B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1 02 13 23 02 13 23 24 29827 LT 80 A 21138 00 1 NPI 1497720825																			
2 02 13 23 02 13 23 24 29826 LT 80 A 15702 80 1 NPI 1497720825																			
3 02 13 23 02 13 23 24 23405 LT 80 A 12951 85 1 NPI 1497720825																			
4 02 13 23 02 13 23 24 29822 59 LT 80 A 15425 00 1 NPI 1497720825																			
5 02 13 23 02 13 23 24 23700 59 80 A 2554 86 1 NPI 1497720825																			
6 02 13 23 02 13 23 24 L3670 A 250 00 1 NPI 1497720825																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 31972Z92068 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File GEORGE PALETTA, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION ST LOUIS SPINE AND ORTHOPEDIC SURADVANCED INJURY CARE 1130 TOWN AND COUNTRY COMMONS TOWN AND COUNTRY, MO 63017-8200									
33. BILLING PROVIDER INFO & PH # (314) 330-4776																			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23										SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. M25512 B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1 02 13 23 02 13 23 24 E0218 A 675 00 1 NPI 1497720825																			
2 02 13 23 02 13 23 24 A9273 A 75 00 1 NPI 1497720825																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 31972Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 750 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File GEORGE PALETTA, M.D. SIGNED 03/31/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION ST LOUIS SPINE AND ORTHOPEDIC SURADVANCED INJURY CARE 1130 TOWN AND COUNTRY COMMONS TOWN AND COUNTRY, MO 63017-8200									
a. NPI										b. NPI									
33. BILLING PROVIDER INFO & PH # (314) 330-4776										8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107									

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> </div> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> </div> </div>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA						3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F			
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA						5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR			
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR			
8. RESERVED FOR NUCC USE						CITY FLORISSANT			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						STATE MO			
10. IS PATIENT'S CONDITION RELATED TO:						ZIP CODE 63034			
11. INSURED'S POLICY GROUP OR FECA NUMBER						TELEPHONE (Include Area Code) () -			
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F			
b. RESERVED FOR NUCC USE						b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE						c. INSURANCE PLAN NAME OR PROGRAM NAME SANSONE & LAUBER			
d. INSURANCE PLAN NAME OR PROGRAM NAME						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 03/31/23									
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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0			
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24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER						F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 02 23 23 02 23 23 11 99024 A						0 00 1 NPI 1497720825			
2						NPI			
3						NPI			
4						NPI			
5						NPI			
6						NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO.			
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 0 00			
29. AMOUNT PAID \$ 0 00						30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File GEORGE PALETTA, M.D. SIGNED 03/31/23 DATE						32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107			
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107						a. NPI b.			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SANSONE & LAUBER
7777 BONHOMME AVE, #2100
SAINT LOUIS, MO 63105

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0									
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4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA										5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR									
8. RESERVED FOR NUCC USE										CITY FLORISSANT STATE MO									
ZIP CODE 63034 TELEPHONE (Include Area Code) () -										ZIP CODE 63034 TELEPHONE (Include Area Code) () -									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										21. RESUBMISSION CODE ORIGINAL REF. NO.									
22. PRIOR AUTHORIZATION NUMBER										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 04 20 23 04 20 23 11 99024 A 0 00 1 NPI 1497720825																			
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 822699429 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 33663Z92068									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 0 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File GEORGE PALETTA, M.D. SIGNED 04/28/23 DATE										32. SERVICE FACILITY LOCATION INFORMATION AIC BRENTWOOD 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107 a. NPI b.									
33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE 8225 CLAYTON ROAD SAINT LOUIS, MO 63117-1107 a. NPI b.																			

11:57 AM

Case 23-13359-VFP Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc

Exhibit E Page 34 of 45

Goldsmith MediCenter Pharmacy

13354 Manchester Rd.

Saint Louis, MO 63131

Phone:(314) 432-5020 Fax:(314) 432-5026

Fed. Id:81-3435121 NABP:2643662

NPI:1730638958

03/13/2023

COX SMITH, CARLA

1018 TRIFECTA DR

FLORISSANT, MO 63034

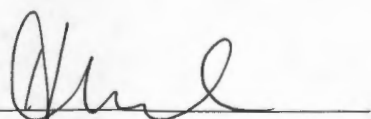
Phone:(314) 914-5663 Cell:() -

DOB: [REDACTED]

Profile From:05/12/2022 thru 03/13/2023

Fill Date ▲	Rx Num.	Qty	Drug	NDC	Doctor	Copay	Day Supply
09/01/2022	3025257	1	DIAZEPAM 10MG TABLET	00172-3927-80	BARTMESS, SAMUEL	\$10.00	1
09/01/2022	2063943	1	HYDROCODONE/APAP 10-325MG TABLET	00406-0125-10	BARTMESS, SAMUEL	\$10.00	1
02/08/2023	1184026	10	ONDANSETRON 8MG TABLET	16714-0160-01	PALETTA, GEORGE	\$391.29	4
02/08/2023	1184025	20	KETOROLAC 10MG TABLET	00093-0314-01	PALETTA, GEORGE	\$47.14	5
02/08/2023	2068970	30	HYDROCODONE/APAP 7.5-325MG TABLET	43386-0357-01	PALETTA, GEORGE	\$27.11	5
						\$485.54	

Pharmacist





7777 BONHOMME AVE SUITE 2100
SAINT LOUIS MO 63105

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 358562993	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX SMITH, CARLA,		3. PATIENT'S BIRTH DATE (MM DD YY) <input type="checkbox"/> SEX <input type="checkbox"/> F <input checked="" type="checkbox"/> F	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX-SMITH, CARLA		5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR	
8. RESERVED FOR NUCC USE		CITY FLORISSANT STATE MO	
CITY FLORISSANT STATE MO		ZIP CODE 63034 TELEPHONE (Include Area Code) (314) 9145663	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO MO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME HAZEL WOOD SCHOOL DIST		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED SOF DATE 03 07 2023		a. INSURED'S DATE OF BIRTH (MM DD YY) <input type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> F	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 12 2022 QUAL. 431		b. OTHER CLAIM ID (Designated by NUCC)	
15. OTHER DATE QUAL. 439 MM DD YY 05 12 2022		c. INSURANCE PLAN NAME OR PROGRAM NAME	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN GEORGE A PALETTA MD		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NILATERAL		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		SIGNED SOF	
A. G89.18 B. C. D. E. F. G. H. I. J. K. L.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
1 02132023 22 64415 59 LT A 1200 00 1 NPI 1114901865		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
2 02132023 22 64999 51 59 LT A 880 00 1 NPI 1114901865		22. RESUBMISSION CODE ORIGINAL REF. NO.	
3 02132023 22 76942 26 59 A 1050 00 1 NPI 1114901865		23. PRIOR AUTHORIZATION NUMBER	
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 204112248 <input type="checkbox"/> <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 3290096820	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 3130.00 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JIMMIE H JEFFRIES, DO		32. SERVICE FACILITY LOCATION INFORMATION STL SPINE/ORTHO CTR ACUTE 1130 TOWN & COUNTRY CMNS CHESTERFIELD MO 63017-8200	
SIGNED 03 07 2023		33. BILLING PROVIDER INFO & PH. # 866 6060153 PREMIER ANESTHESIA, LLC PO BOX 5480 CAROL STREAM IL 60197-5480	
a. NPI b. 1225073828			



7777 BONHOMME AVE SUITE 2100
SAINT LOUIS MO 63105

STL1
329

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE (Medicare #)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE (MM DD YY)		6. PATIENT RELATIONSHIP TO INSURED	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED SOF		SIGNED SOF	
DATE 03 07 2023		DATE 03 07 2023	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. M75.102 B. M75.42 C. S43.432A D. ICD Ind. 0		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1. BEG=1445 END=1631 BASEU= 5 MIN= 106 TIMEU= 8.00 TOTU= 13.0			
2. 02132023 22 01630 QZ P2 ABC 1950 00 106 NPI 1770564957			
3. 02132023 22 01630 QZ P2 ABC 1950 00 106 NPI 1770564957			
4. 02132023 22 01630 QZ P2 ABC 1950 00 106 NPI 1770564957			
5. 02132023 22 01630 QZ P2 ABC 1950 00 106 NPI 1770564957			
6. 02132023 22 01630 QZ P2 ABC 1950 00 106 NPI 1770564957			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE	
29. AMOUNT PAID		30. Rsvd for NUCC use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH. #			
SIGNED 03 07 2023		a. 1225073828 b.	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 358562993	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX-SMITH, CARLA		4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX-SMITH, CARLA	
5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR CITY FLORISSANT STATE MO ZIP CODE 63034 TELEPHONE (Include Area Code) (314) 9145663		7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR CITY FLORISSANT STATE MO ZIP CODE 63034 TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME UNKNOWN		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? 10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SOF DATE 08 01 2023	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SOF		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 12 2022 QUAL. 431 15. OTHER DATE QUAL. 439 MM DD YY 05 12 2022	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN GEORGE A PALETTA MD		17a. IGG20068 17b. NPI 1497720825	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NILATERAL		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. G89.18 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 07172023 22 64415 59 LT A 1160 00 1 NPI 1114901865			
2 07172023 22 64999 51 59 LT A 1080 00 1 NPI 1114901865			
3 07172023 22 76942 26 59 A 1040 00 1 NPI 1114901865			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 204112248 X 3290099114		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JIMMIE H JEFFRIES, DO SIGNED 08 01 2023		32. SERVICE FACILITY LOCATION INFORMATION STL SPINE/ORTHO CTR ACUTE 1130 TOWN & COUNTRY CMNS CHESTERFIELD MO 63017-8200	
33. BILLING PROVIDER INFO & PH. # (877) 7467090 PREMIER ANESTHESIA, LLC PO BOX 5480 CAROL STREAM IL 60197-5480		34. TOTAL CHARGE 3280 00 \$ 35. AMOUNT PAID 0 00 \$ 36. Rsvd for NUCC use	



7777 BONHOMME AVE SUITE 2100
SAINT LOUIS MO 63105

STL1
329

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 358562993	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) COX-SMITH, CARLA		4. INSURED'S NAME (Last Name, First Name, Middle Initial) COX-SMITH, CARLA	
5. PATIENT'S ADDRESS (No., Street) 1018 TRIFECTA DR CITY FLORISSANT STATE MO ZIP CODE 63034 TELEPHONE (Include Area Code) (314) 9145663		7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR CITY FLORISSANT STATE MO ZIP CODE 63034 TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME UNKNOWN		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? 10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SOF DATE 08 01 2023		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 12 2022 QUAL. 431 15. OTHER DATE QUAL. 439 MM DD YY 05 12 2022	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN GEORGE A PALETTA MD 17a. 1GG20068 17b. NPI 1497720825	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? \$ CHARGES YES NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. M75.102 B. M75.42 C. D. E. F. G. H. I. J. K. L.	
22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINT OF F. CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1. BEG=1254 END=1429 BASEU= 5 MIN= 95 TIMEU= 7.00 TOTU= 12.0 E1 066039 07172023 22 01630 QZ P1 AB 1800 00 95 NPI 1174504054			
2.			
3.			
4.			
5.			
6.			
25. FEDERAL TAX I.D. NUMBER SSN EIN 204112248 X		26. PATIENT'S ACCOUNT NO. 3290099113	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO		28. TOTAL CHARGE \$ 1800 00\$ 29. AMOUNT PAID 0 00 30. Rsvd for NUCC use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) DAVID SCHMITT, CRNA SIGNED 08 01 2023		32. SERVICE FACILITY LOCATION INFORMATION STL SPINE/ORTHO CTR OR OP 1130 TOWN & COUNTRY CMNS CHESTERFIELD MO 63017-8200 a. NPI b.	
33. BILLING PROVIDER INFO & PH. # (877) 7467090 PREMIER ANESTHESIA, LLC PO BOX 5480 CAROL STREAM IL 60197-5480 a. 1225073828 b. E1066039			

CERTIFICATION OF MEDICAL RECORDS 239345

Patient Name: Carla Cox

I hereby certify that the documents attached to/accompanying this certificate, consisting of 8 pages and/or images, for Total Access Urgent Care, or otherwise if delivered in an electronic format, are accurate and complete duplicates of the original medical/billing records of the patient listed above.

Exclusions: None / As follows: _____

OR: Certification of No Records (CNR): A thorough search of the files at this location revealed no documents, medical records or other materials requested. I further certify that the produced records are a true copy of all records requested and are kept in the course of regularly conducted activity. CNR executed this _____ day of _____, 202__.

On behalf of the Records Custodian, I am an employee of BHS, the Business Associate charged with performing such searches and certifications.

(Signature) Christie Bianchi(Printed Name) Christie Bianchi(Date) 3/9/23

Case 23-13359-VFP
Total Access Urgent Care
Billing Department
13861 Manchester Road
St. Louis, MO 63011

Doc 2791-7

Filed 01/12/24

Entered 01/12/24 14:53:30

Desc

Exhibit E Page 40 of 45

IF PAYING BY CREDIT CARD FILL OUT BELOW

<input type="checkbox"/> MASTERCARD		<input type="checkbox"/> VISA
CARD NUMBER		EXP. DATE
SIGNATURE		AMOUNT ENCLOSED
STATEMENT DATE 3/22/2023	ACCT# 1032699	

CARLA B COX
1018 TRIFECTA DR
FLORISSANT, MO 63034

Total Access Urgent Care
Billing Department
13861 Manchester Road
St. Louis, MO 63011

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse

To pay your bill online go to: TAUC.com and select Bill Pay

ACCOUNT SUMMARY

<p><u>The Insurance Companies on file for these visits:</u> CARLA COX Blue Cross/Blue Shield Medicare</p>	Out to insurance: \$0.00 You have paid \$0.00 as copays that are still pending.
	You have \$39.65 currently in your responsibility. You have \$0.00 available as a credit. You owe \$39.65 today.

Visit Date: 05/13/2022

Visit ID: 3642608

Patient: CARLA

Location: TAUC12

Physician: Morgan Baer, PA-C

	CHARGES	INSURANCE PAYMENT	CONTRACT SAVINGS	PATIENT PAYMENT	ADJUSTMENT	BALANCE	RESPONSIBLE PARTY	DENIAL CODE
72072 X-ray thoracic spine 3 view	\$123.62	\$30.06	\$90.19	\$0.00	\$0.00	\$3.37	Patient	COPAY
72110 X-ray lumbar spine, min 4 views	\$258.74	\$39.31	\$215.03	\$0.00	\$0.00	\$4.40	Patient	COPAY
IA INITIAL ASSESSMENT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
LEAVE PATIENT READY TO DISCHARGE	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
99214 Established 4	\$318.00	\$97.20	\$209.93	\$0.00	\$0.00	\$10.87	Patient	COPAY
72050 X-ray cervical spine, 4+ views	\$250.89	\$40.85	\$205.47	\$0.00	\$0.00	\$4.57	Patient	COPAY
	\$951.25	\$207.42	\$720.62	\$0.00	\$0.00	\$23.21		

Visit Date: 05/13/2022

Visit ID: 3642879

Patient: CARLA

Location: TAUC12

	CHARGES	INSURANCE PAYMENT	CONTRACT SAVINGS	PATIENT PAYMENT	ADJUSTMENT	BALANCE	RESPONSIBLE PARTY	DENIAL CODE
MED033 Methocarbamol	\$15.00	\$0.00	\$0.00	\$15.00	\$0.00	\$0.00		
MED034 Hydrocodone/APAP	\$15.00	\$0.00	\$0.00	\$15.00	\$0.00	\$0.00		
	\$30.00	\$0.00	\$0.00	\$30.00	\$0.00	\$0.00		

Thank you for your timely payment. Please be aware, that in the event of non-payment, you will be responsible for the collection fee and, if necessary, legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.

For questions regarding your account, please call 1(636)-556-0114.

Case 23-13359-VFP Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc

A finance charge is computed on a monthly periodic rate of 0.00%, 0% annually on any balances over 0 days.

Exhibit E Page 41 of 45

<u>PATIENT OWES:</u>
\$39.65
<u>INSURANCE OWES:</u>
\$0.00

Explanation of outstanding balance(s):

COPAY: COPAY

Thank you for your timely payment. Please be aware, that in the event of non-payment, you will be responsible for the collection fee and, if necessary, legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.

For questions regarding your account, please call 1(636)-556-0114.

Medical Bills:

Name of the Provider	Billing Amount
Advanced Injury Care	\$ 121,154.08
Goldsmith Pharmacy	485.54
Premier Anesthesia	5,080.00
Total Access Urgent Care	981.25
St. Luke's CDI	4,763.00
St. Louis Spine & Orthopedic Center	87,206.35
Professional Imaging	5,000.00
Athletico	14,480.00
Lehmen	5,250.00
TOTAL	\$ 244,400.22

ADVANCED INJURY CARE

Surgical Consult Note

8225 Clayton Road, Saint Louis, MO 631171107

CARLA COX SMITH

MRN :

Birthday : **1959-11-22**

Phone :

Visited on: 2022 Dec 15 13:40 (Age at visit: 63 years)

Electronically signed by: GEORGE PALETTA, M.D. on 2022-12-22 09:06 AM

HPI

This the first visit for this 63 year old right hand dominant female. She presents for evaluation of a chief complaint of left shoulder pain, weakness and limited range of motion. This dates to an injury which occurred on May 12, 2022. On that date, she was shopping in a Bed, Bath and Beyond. She had a shopping cart with her. She was standing in one of the aisles or walkways. Apparently, an employee was pushing a cart that was filled with material and was piled high enough that the employee couldn't see her. She was hit directly from behind by this cart that was being pushed by the employee. It hit her directly in the back, injuring her neck, low back and left shoulder. She was knocked forward but did not fall to the floor. There was no loss of consciousness. She had immediate left shoulder pain in addition to her back and neck pain. She did not receive any medical attention that day, but believes the next day is when she first went to urgent care.

Ultimately, she was seen at Advanced Injury Care and underwent evaluation and treatment for both the neck and back problem as well as the shoulder problems. With respect to the neck, she underwent an MRI scan which showed evidence of previous anterior cervical fusion at C 5 - C 7. She had some disc pathology above and below the site effusion and she has had two injections of the cervical spine. She states the neck is doing "ok" at this point. There has not been any discussion of further surgical treatment for the neck.

With respect to the back, she was diagnosed with disc pathology, particularly at the L 4 – 5 level and has consulted with Dr. Lehman. The recommendation has been made for consideration for surgical treatment for the lumbar spine but not surgery has been scheduled.

Her third problem was that of the shoulder. She states that she has had difficulty with continued pain radiating down the arm. No associated numbness, tingling or paresthesias. She has difficulty with active motion and finds herself markedly limited with regard to the ability to forward flex or abduct the shoulder. She states, that prior to the incident of injury in May, she had no issues related to the shoulder. She has had no injections for the shoulder. The exception to that is her primary care physician did one injection. She states the injection performed by her primary care physician did not result in significant relief.

Past medical history, past surgical history, medications, allergies, review of systems, family history, and social history are as per the intake questionnaire, which I have personally reviewed.

EXAM

Well-developed, well nourished, well appearing female in no acute distress. She is alert and oriented. She is pleasant and cooperative. Examination of the right shoulder is normal. Left shoulder reveals no asymmetry, muscle atrophy or deformity is noted. There is no tenderness at the AC joint, SC joint and bicipital groove. She has limited active range of motion. She complains of pain with attempts at forward flexion and can get to about 60 degrees. Abduction is to about 50 degrees. Passively, she can get to about 120, but she cannot maintain the arm in a position of abduction or forward flexion as she demonstrates a positive drop sign. With the arm to the side she externally rotates to about

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20. Internal and external rotation strength are 5/5. Again, she has marked weakness of the supraspinatus. With a positive drop test, it was difficult to assess true strength. No instability. Neurovascular status is intact.

Results

RADIOLOGIC EXAM: X-rays available for review include a left shoulder series with AP of the glenohumeral joint in internal and external rotation, axillary, outlet and AP of the shoulder. These demonstrate AC joint degenerative changes which are age appropriate. The glenohumeral joint is well maintained.

MRI SCAN: MRI scan available for review is the study that was completed at Professional Imaging on October 4, 2022. I personally reviewed the study. It is a well done study of diagnostic quality. It demonstrates several abnormalities. There is an effusion as well as fluid in the subacromial space. Those are contiguous, consistent with a tear of the rotator cuff. There is a complete tear of the supraspinatus with minimal retraction. There is no atrophy of the supraspinatus muscle belly or fatty infiltration. The subscapularis is intact. The posterior cuff appears normal. There is irregularity of the labrum, but in my opinion, it does not appear consistent with a frank labral detachment or SLAP lesion. There are hypertrophic degenerative changes at the AC joint.

Assessment

Full thickness rotator cuff tear, supraspinatus tendon, left shoulder.

Plan

I had a long discussion with the patient regarding the diagnosis and condition affecting her left shoulder. She certainly has symptoms and physical exam findings consistent with a symptomatic rotator cuff tear. However, I explained to her that pain that comes all the way down the arm sometimes originates from the neck. She clearly has a neck issue and a shoulder issue. It is my opinion that physical therapy and injections of the shoulder are not likely to be beneficial and that she needs to consider arthroscopy with rotator cuff repair. I discussed with her the surgical procedure as well as the expected postop recovery and rehabilitation requirements. I explained to her that if she has the shoulder surgery done, it would likely be six weeks before she could consider the back surgery after the shoulder surgery. It might be worthwhile to consult with Dr. Lehman to find out how soon after the back surgery she could potentially have shoulder surgery so we could figure out which one to prioritize and potentially do first.

I do think it would be beneficial to get her into a little bit of physical therapy for the shoulder at this point to prevent her from developing adhesive capsulitis or frozen shoulder. However, I do not think that physical therapy will be the long term solution without surgical repair of the tear of the rotator cuff.

It is my opinion, based on the history provided to me by the patient and the absence of any prior history of left shoulder problems, that the injury incident of May 12, 2022, is a contributing or causative factor to her current left shoulder condition. Additionally, there

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is no evidence of a chronic long standing rotator cuff tear as there is no cuff retraction, supraspinatus or muscle belly atrophy or fatty infiltration of the supraspinatus.

George A. Paletta, Jr., M.D.

GAP:sdm

This report was dictated by#George A. Paletta, Jr., M.D.#and approved without proofreading/editing to expedite distribution.